CHAMPVA POLICY MANUAL

CHAPTER: 3
SECTION: 6.1
TITLE: SKILLED NURSING FACILITY (SNF) REIMBURSEMENT

AUTHORITY: 38 USC 1713 and 38 CFR 17.270 and 17.272(b)

RELATED AUTHORITY: 32 CFR 199.14(b)

TRICARE POLICY MANUAL: Chapter 13, Section 7.1

I. EFFECTIVE DATE

August 26, 1985

II. DEFINITION

A. A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. SNFs must have state licensure to provide skilled care and must be certified by Medicare. It is critical to note that the designation "skilled nursing facility" does not automatically mean that all patients in that particular facility are classified as skilled or are receiving a skilled level of care.

B. A skilled nursing service is a service that can only be furnished by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.), and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired results. Skilled nursing services are other than those services that could be performed by a layman adult with minimum instructions or supervision. (For example, the pre-filling of insulin syringes can be safely done by a nonmedical person without direct nursing supervision. Therefore, teaching how to pre-fill the syringe would be skilled, but pre-filling the syringes on an ongoing basis would not be skilled.) A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse (see Chapter 3, Section 5.7, *Skilled Nursing Reimbursement (Home Health)*.

Note: The presence of a urethral catheter, particularly one placed for convenience of the control of incontinence, does not justify a need for skilled nursing care.

C. Skilled rehabilitation services are those services that are ordered by a physician and require the skills of health professionals such as physical therapists, occupational therapists, speech pathologists and/or audiologists. When rehabilitation services are the primary services rendered, the key issue is whether the services of a therapist are needed. If the complexity of the service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled rehabilitation personnel, the service is a skilled nursing care service.

III. POLICY

A. Care in an SNF is covered if ALL of the following factors are met:

1. the patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; and

2. The patient requires these skilled services on a daily basis.

If either one of the above factors is not met, a stay in an SNF, even though it might include the delivery of some skilled services, is not covered.

B. The services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a patient's illness or injury; i.e., be consistent with the nature and severity of the individual's illness or injury, particular medical needs, and accepted standards of medical practice. The services must be reasonable in terms of duration and quantity. The skilled level of care must be documented by the physician.

C. Benefits are payable if the required daily skilled care can only be provided in a skilled nursing facility on an inpatient basis. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

D. Nursing progress notes are to be submitted each month for review to determine that the skilled level of care is still maintained. Only the dates of service for skilled level of care that are supported by documentation will be covered.

E. Payment for an SNF stay is not covered if the patient's level of care is determined to be intermediate. An intermediate level of patient care may at some time require a skilled level of care based on a change in the medical condition (i.e., pneumonia, urinary tract infection or wound care). If the physician's treatment orders and documentation support the skilled level of care for a brief period of time, then those dates of service may be covered.

F. Therapeutic leaves of absence from a skilled nursing facility will be considered for payment with supporting medical documentation.

IV. REIMBURSEMENT

A. Claims for SNF reimbursement are paid using the cost-to-charge payment methodology.

B. All skilled nursing facility claims are subject to medical review. In the event the documentation does not support a skilled level of care, the claim will be denied. Room and board and nursing services must be entered as a daily rate. Charges for pharmacy and medical/surgical supplies must be itemized.

C. Durable medical equipment (DME). Charges for DME items are subject to review.

D. Claims with an all-inclusive billing rate will be considered if the provider is incapable of providing an itemized billing statement and also certifies that the all-inclusive rate is uniformly charged to all patients.

E. Claims for skilled rehabilitation services must include the treatment notes with dates of service, as well as summaries of care.

V. POLICY CONSIDERATIONS

See Chapter 3, Section 5.7, *Skilled Nursing Reimbursement (Home Health)* policy.

VI. EXCLUSIONS

A. Over-the-counter medications and personal care items, including incontinent care items are not covered benefits.

B. Services received which are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine are not covered.

C. Facility charges for room holds while the patient is out of the facility are not a covered benefit.

END OF POLICY